

1606-A Wellington Ave.

Wilmington, NC 28401 910-859-8586 fax 910-859-8588

**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Primary Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married Single Widowed Divorced Separated

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party (Parent, Guardian, or Power of Attorney)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |
| --- | --- |
|  |  |
| 1606-A Wellington Ave. | Office Hours: |
| Wilmington, NC 28401 | Monday: 8:00 am - 5:00 pm |
|  accessinternalmedicine@gmail.com | Tuesday: 8:00 am - 5:00 pm |
| phone 910-859-8586 | Wednesday: 8:00 am - 5:00 pm |
| fax 910-859-8588 | Thursday: 8:00 am - 3:00 pm |
| After Hours Phone: 910-859-8586 | Friday: 8:00 am - 12:00 pm |

**Welcome to Access Internal Medicine, PC. Please take a moment to read carefully and sign this form. We hope this will introduce you to our goals and expectations**.

To meet our goals we may need frequent visits for education about the suspected/existing condition, treatment options, discussion, and testing. We believe that patient education and providing evidenced based care is extremely important. Access Internal Medicine encourages and guides our patients to take an active role in their health care. In most cases this implies significant effort and compliance with the treatment plan, required testing and appointments. This process may be difficult and time consuming but the payoff is to reach our ultimate goal –the highest possible level of quality life and maintenance of the quality of life for the longest possible time. We provide personalized and comprehensive primary care and take pride in prompt, unhurried appointments with direct access and a strong focus on health and wellness.

Our model of practice provides both provider and patient with quality time together to deal with not only complex health issues but a focus on disease-prevention and proactive wellness. Access Internal Medicine offers same day and next day appointments, 24/7 telephone access to a provider, video conferencing and house calls when medically necessary. We will coordinate your care with specialists, behavioral health, fitness and nutrition providers as well as urgent care and hospitals. Our practice also provides wellness events, weight loss counseling, travel medical services and online patient portal. We believe whole-person, comprehensive care is the key to health and wellbeing.

**No Shows**: In order to maintain the quality of our practice, we must ask for 24-hour notice if you are unable to keep your scheduledappointment. If we do not receive this notice, you will be charged a **$50.00 No Show Fee**. If you no show to three consecutive appointments, **you will be discharged from the practice**. Please keep in mind we do make reminder calls **as a courtesy, but it is** **your responsibility to keep track of your appointments.**

**Medications:** Each time you have an appointment, please **bring ALL** of your medication bottles with you. Also, please keep a list ofmedications and allergies with you.

**Noncompliance:** Noncompliance with the treatment plan that we discuss may jeopardize your health**. Persistent noncompliance without understandable reasons will show a lack of interest on your part and would place doubt in our role as your primary care provider**. This will result in **dismissal from the practice**.

**Long Term Pain Management**: We are not specialists in long term pain management, especially with controlled substances. Iftreatment for pain is needed for more than two (2) months, the expertise of a pain clinic will possibly be required at the discretion of your provider. During any extended treatment, a pain management contract will be required.

**LAB HOURS: M-W** 7:30am-12:30 & 1:30-4:30 **Thursday** 7:30am-2:30pm **Friday** 7:30-12:30

During office hours, you may schedule appointments, leave messages for your provider or medical assistant or request a written prescription refill. You may also do all this through our patient portal 24-7. All other prescription refills should be initiated and faxed by your pharmacy. Please allow 24-48 hours for your prescription refill to be processed. Please do not wait until you are completely out of medicine to inform us or your pharmacy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment and Healthcare Operations**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** understand that as part of my healthcare, Access Internal Medicine, PC originates and maintainspaper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as

* A basis for planning my care and treatment,
* A means for communication among the many healthcare professionals who contribute to my care,
* A source of information for applying my diagnosis and surgical information to my bill,
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health information for directory purposes, and
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Access Internal Medicine, PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Access Internal Medicine, PC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Access Internal Medicine, PC change their notice, they will send a copy of any revised notice to the address I have provided (whether US mail or, if I agree, email.)

**I give my permission for the following person(s) family members/relatives to have access to my medical records or ask questions regarding anything having to do with my healthcare**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I give my permission for messages to be left at the following numbers regarding appointment dates and times, test results and healthcare concerns:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that as a part of this organization’s treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

**I fully understand and accept/decline the terms of this consent. Patient/Guardian**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INSURANCE AUTHORIZATION & ASSIGNMENT**

I hereby authorize Access Internal Medicine, PC to furnish information to insurance carriers, my employer (if applicable) or the Healthcare Financing Administration and its agents concerning my illness and its treatments. I authorize insurance or Medicare benefits to the provider for services rendered, where applicable.

**Please bring your insurance card(s) to each and every visit, as we will ask you for it to insure that we have the correct info and updated card copy.**

If we do not participate with your insurance provider, we will file your insurance, as a courtesy for you and you will be responsible for your payment in full the day of your appointment. Please be aware that your insurance company may consider your bill as a non-covered service and may not pay for the services provided.

Full payment (if self-pay) or insurance co-payments are due at the time of service when checking in. If you are unable to pay your co-pay we will reschedule your appointment. Any previous balance is expected in full unless other arrangements have been made with the billing department prior to being seen by the provider. We accept Visa/MasterCard/Discover, cash or check. A payment plan can be set up for any outstanding balances. There will be a $25 Return Check Policy.

Minor Patients: The parent/guardian is responsible for full payment. We may refuse non-emergent care to any minor that is unaccompanied by a parent/guardian, unless prior permission is given in writing or by phone.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INSURANCE** | **Cardholder name** | **ID #** | **SS#** | **DOB** |
| **INFORMATION** |  |  |  |  |
| Name of Primary |  |  |  |  |
| Insurance: |  |  |  |  |
|  |  |  |  |  |
| Secondary Insurance: |  |  |  |  |
|  |  |  |  |  |

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 4



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**Missed Appointment Policy**

Access Internal Medicine, PC will be charging a fee of $50.00 for missed appointments in which prior notice was not given. Due to the increased number of patients who do not call and do not show up for their appointments we are forced to put this policy into place. We apologize for this inconvenience to our patients who are diligent in notifying us of their scheduling conflicts.

Please sign below stating, “I understand if I do not show up for my appointment and do not call to cancel or reschedule my appointment I will be responsible for a charge of $50.00. I further understand I will be responsible for paying this fee prior to my next appointment.”

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name** **Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**Patient Portal with Athena Health**

Communicate with our office using the secure and efficient patient portal. All you need is an email address to sign up. This service will allow you to send messages to your physician and the office, request refills, review your lab results, request appointments and review upcoming appointments, update your address and phone numbers and review your current billing statement.

**If you are interested, please complete the following:**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**We will provide you with a username, password and instructions on how to use the patient portal.**

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**HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Health History**

**Immunizations and dates:**

o Tetanus \_\_\_\_\_\_\_\_\_\_

o Tdap\_\_\_\_\_\_\_\_\_\_\_\_

o Shingles \_\_\_\_\_\_\_\_\_\_

o HPV\_\_\_\_\_\_\_\_\_\_\_\_\_

o Influenza\_\_\_\_\_\_\_\_\_\_\_

o Hepatitis\_\_\_\_\_\_\_\_\_\_\_

o Pneumonia\_\_\_\_\_\_\_\_\_\_\_

o Chickenpox\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| o MMR (Measles, Mumps, Rubella)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| **Past Medical History:** |  |  |  |  |  |
| ( )Blood Pressure ( )Heart Disease ( )Cholesterol ( )Coronary Artery Disease | ( )Anxiety |
| ( )Depression | ( )Diabetes | ( )Gerd/Reflux/Heartburn | ( )COPD ( )Asthma | ( )Seasonal Allergies |
| ( )ADD/ADHD | ( )Thyroid | ( )Changing Mole | ( )Stroke | ( )Tuberculosis | ( )Cancer |
| ( )Arthritis ( )Kidney Disease ( )Liver Disease | ( )Gout | ( )Fibromyalgia | ( | )Osteoporosis |

**Surgical History**

Year: \_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. or Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. or Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. or Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. or Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Prescribed and Over the Counter Medications:**

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Strength\_\_\_\_\_\_\_\_Frequency Taken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do not wait until you are out of your medication to call for a refill. Refills can take up to 3 days to complete.
* Lost or stolen medications will not be replaced.
* All **controlled prescription refills** require an office visit **every 1 or 3 months depending on the** **medication.**

**Allergies to Medications:**

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction you had\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction you had\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction you had\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Environmental Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Access Internal Medicine can test and treat allergies!***

**Family History:**

Problem Onset Age Notes Died of Age

Mother :

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| History of abnormal pap: | yes | no | **Gynecology History:** |  |
|  |  |
| Hysterectomy: complete | or | partial | Reason for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History:**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Exercise: | none | occasional | moderate | heavy |
| Alcohol intake: | none | occasional | moderate | heavy |
| Caffeine intake: | none | occasional | moderate | heavy |

Diet restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illicit Drug use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking: never smoked former smoker current smoker

Smoking: How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age started smoking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an advanced directive or living will? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list name and location of any other health care providers you see:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Phone Number: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release the following information to Jeremy Pepper, PA-C of Access Internal Medicine, P.C.

reason for this medical record release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

please include the following information for access internal medicine, p.c. in this record release:

* all prior medical history documented by the facility to present
* only medical information relating to the time period \_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_
* only information specifically requested as outlined: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

i do not want the following information disclosed in this request:

* sexually transmitted disease (std) test results
* aids/hiv test results
* any records regarding drug, alcohol, or mental health treatment

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

please return this completed form to our office:

1606-A Wellington Avenue, Wilmington, NC 28401

Phone: (910) 859-8586

Fax: (910) 859-8588

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